ELITE SEDATION

INFORMED CONSENT AND RECORDS RELEASE FOR ANESTHESIA

The following is provided to inform patients of the choices and risks involved with having treatment under anesthesia. This information is not presented to make patients apprehensive but to enable them to be better informed concerning their treatment. The choices for anesthesia are: local anesthesia alone, local with intravenous sedation, or general anesthesia. These are administered depending upon each individual patient's unique requirements.

The side effect seen most frequently of any intravenous infusion is phlebitis which occurs only 2-4 percent of the time. Phlebitis is a raised, tender, hardened, inflammatory response at the site of the injection which can have onset from 24-48 hours up to two weeks after the procedure. The inflammation usually resolves with local application of warm (100°F) moist heat, yet tenderness and a hard lump may be present up to a year.

I,_____ , hereby authorize and request _____, D.D.S. to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic or anesthetics (from local to general) by any method that is deemed suitable by the anesthesiologist. It is the understanding of the undersigned that the anesthesiologist is an independent contractor and consultant and will have full charge of the administration and maintenance of the anesthesia, which is an independent function of the surgery/ dentistry. I also understand that the anesthesiologist has no responsibility for the dentistry to be performed or the diagnosis or treatment planning involved in dentistry.

I have been informed and understand that occasionally there are complications of the local anesthesia and medications, including but not limited to: pain, hematoma, temporary or permanent numbness of the face, teeth, tongue, lip or gums, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, stroke, and heart attack. I further understand and accept the risk that very rare complications may require hospitalization that could result in death. I have been made aware that the risks associated with local anesthesia, conscious sedation, and general anesthesia vary. Of the three, local anesthesia is usually considered to have the least risk and general anesthesia is the greatest risk. However, it must be noted that local anesthesia alone may not be appropriate for every patient and every procedure and that local and sedation may be safer than local alone.

I understand that anesthetics, medication, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the anesthesiologist of any possibility of pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For similar reasons I understand that I must inform the anesthesiologist if I am a nursing mother.

Because medication, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination which can be increased by the use of alcohol or other drugs, I have been advised not to operate any vehicle or hazardous device for at least twenty-four (24) hours or longer until fully recovered from the effects of the anesthetic, medications, and drugs that may have been given to me for my care. I have been advised not to make any major or important decisions until after full recovery from the anesthesia. I understand that those with a history of chemical or alcohol dependency have a possible risk of relapse after anesthesia and should take appropriate precautions and support options.

I have been fully advised of and accept the possible risks and dangers of anesthesia. I acknowledge the receipt of, understand and agree to follow both pre and post-operative anesthesia instructions. It has been explained to me and I understand that there is no warranty or guarantee as to any result and/or cure. I have had the opportunity to ask questions about my anesthesia and I am satisfied with the information provided to me**. I also request that my physician's release to the anesthesiologist any information he desires regarding my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to my surgery and anesthetic management**. I also authorize the anesthesiologist to speak with my spouse, parents or children regarding any phase of my treatment.I have received a copy of instructions and this consent.

Patient Signature: _____ **Date:** _____

Witness Name:_____ **Witness Signature:**_____

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ELITE SEDATION

PATIENT HEALTH HISTORY

Name: _____ **Birth Date:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home/Cell Phone: _____ **Email:** _____

Emergency contact: _____ **Phone:** _____

Medical History

1. Height: _____ Weight: _____
2. Is the patient currently under the care of a physician for a specific condition? _____ ☐ Yes ☐ No
3. Date of last physical exam? _____
4. Date of last cold, cough or fever? _____
5. Physician: _____ Phone Number: _____
6. Please describe patient's current physical health: ☐ Excellent ☐ Good ☐ Poor
7. Please describe patient's routine physical activity: _____
8. Does the patient experience shortness of breath? ☐ At rest ☐ minimal exertion ☐ moderate exertion
9. Has there been any changes in health in the last year? _____ ☐ Yes ☐ No
10. Has the patient had any recent hospitalizations or surgeries? _____ ☐ Yes ☐ No
    a. If yes, when and why _____
11. Does the patient have cardiovascular disease? _____ ☐ Yes ☐ No
    a. If yes, circle- arrhythmia, chest pain, coronary artery disease, heart attack, heart failure, heart valve disease/replacement, hypertension, pacemaker/defibrillator, stents
    Other _____
12. Does the patient have pulmonary disease or symptoms? _____ ☐ Yes ☐ No
    a. If yes, circle- asthma, bronchitis, emphysema, persistent cough, tuberculosis, wheezing
    Other _____
13. Has the patient ever been diagnosed with sleep apnea? _____ ☐ Yes ☐ No
14. Has the patient ever had any of the following medical problems?

☐ Arthritis
☐ Bleeding Problems / Bruise easily
☐ Blood disorder
☐ Cancer
☐ Diabetes
☐ Fainting episodes
☐ Hepatitis / Liver problems
☐ Kidney Problems
☐ Muscle weakness
☐ Seizures / Epilepsy
☐ Stroke
☐ Other _____

15. Please list all medications the patient is currently taking: _____
_____
16. Please list all allergies to medication or food: _____

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PATIENT HEALTH HISTORY

**** Questions 17 – 23 are for adults and teens only ****

17. Do you smoke? If yes- how long? Packs/day?_____ ☐ Yes ☐ No
18. Do you drink alcohol? If yes, how much?_____ ☐ Yes ☐ No
19. Do you use recreational drugs? If so, what drug and when?_____ ☐ Yes ☐ No
20. Have you or a close relative ever had a bad reaction to any anesthetic drug?_____ ☐ Yes ☐ No
21. Have you ever had complications during a previous anesthetic?_____ ☐ Yes ☐ No
22. What is your anxiety level related to dental treatment? ☐ Mild ☐ Moderate ☐ Severe
23. WOMEN: Is there any possibility that you could be pregnant?_____ ☐ Yes ☐ No

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform the anesthesiologist of any changes in my medical status at the earliest possible time.

Signature of Patient: _____ **Date:**_____

Reviewed by:_____ **Date:**_____

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PRE-ANESTHESIA SERVICES

Communication

● ____I agree that if the office and or Anesthesiologist is unable to reach me prior to my scheduled appointment date, my appointment will be canceled.

● ____I am aware that if I missed the call or have any questions I will call the Anesthesiology Team/ELITE Sedation at 949-529-9289.

● ____I agree to let the office know as soon as possible if I have to cancel or reschedule my appointment.

Appointment Times

● ____I agree that my scheduled appointment times are tentative and I will be available all day starting at 6am.

● ____I agree that if I am unable to answer the phone or come in when asked my appointment time may be delayed or canceled

Eating / Drinking

● ____For anesthesia, it is of utmost importance that patients have nothing to eat or drink starting at 10pm the night prior to their scheduled appointment. *Failure to strictly follow these instructions could result in aspiration and may be fatal.*

● ____Medications can be taken with a sip of water **IF** instructed by the Anesthesiologist.

● ____I am aware that I am (my child is) to remain NPO (nothing by mouth/fasting requirement) starting from 10pm the night prio to my child's/ the patient's procedure.

● ____I agree to keep my child home from school on the day of his appointment and under strict supervision to ensure NPO compliance.

Change in Health or Medications

● ____A change in health, especially the development of a cold, cough, or fever is *EXTREMELY* important.

● ____I agree to notify the office if there is any change in your child's health. Your appointment may need to be rescheduled.

● ____I have fully disclosed all medications and health history of my child/ the patient. I have been informed this is for the complete safety of my child/ the patient.

Clothing / Diapers / Hair / Jewelry / Blankets

● ____Children should be in loose comfortable clothing.

● ____Please bring a change of clothing in case of any accidents or have your child in a diaper or pull-up.

● ____Tie long hair back in a low ponytail.

● ____Remove all jewelry.

● ____Be sure to bring a small blanket.

DAY OF SURGERY

● ____DO NOT ALLOW YOUR CHILD TO EAT OR DRINK ANYTHING

● ____I am aware as a patient parent/guardian I am not allowed in the operating room at time of surgery.

● ____I have been fully informed as parent /guardian I must be present in the dental office or in my vehicle at all times during the appointment.

● ____I will keep a close eye on my child/ the patient prior to the appointment and for the remainder of the day.

The Anesthesiologist reserves the right to cancel the scheduled surgical appointment for any reason that may jeopardize the safety of the anesthetic procedure.

I, _____, have read and understand the given instructions.

_____ _____

Signature of Patient/Parent or Legal Guardian **Date**

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TRANSPORTATION INFORMATION

PATIENT'S NAME:_____

As you know, a responsible adult must drive you to and from your dental appointment and a responsible adult must stay with you overnight. Advise your driver that they are expected to escort you to the office and wait for about 30 minutes. If you can arrange to have your ride home be the same person who spends the night with you we can give them your post surgical instructions. Unless your ride waits for you in the dental office during your entire appointment, we will need the following information and an alternate driver. We realize that it is extremely unlikely that your ride will fail to return for You, but about twice a year, accidents, car trouble, and illness force us to contact the alternate driver. Without an alternate driver, those patients would have had to have been admitted to a hospital overnight. Therefore it is in everyone's best interest that you complete the following:

Patient/Guardian Signature:_____

Expected Driver's Name: _____ **Phone:**_____

Time (in minutes) needed by driver to return to dental office:_____

Alternate Driver's Name:_____ **Phone:**_____

Phone # where you may be reached after your appointment:_____

Phone # of your pharmacy:_____

My ride will be present throughout the duration of the procedure (Circle): Y N

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ELITE
SEDATION

Photo, Audio, & Video Release Form

I, _____, hereby grant permission to Elite Sedation General Partnership ("Elite Sedation" or the "Company") and its employees to take photographs, audio, and/or videos (collectively referred to as "multimedia") of me, my likeness, and my overall appearance during my visit/appointment.

I understand that multimedia may be used for educational, training, and marketing purposes, including but not limited to social multimedia, websites, print materials, and other forms of marketing. I understand that Elite Sedation has the right to edit and use these multimedia as they see fit.

I also understand that I will not receive any form of compensation or financial remuneration from the use of these multimedia.

I also understand that once the multimedia is used, Elite Sedation has no control over the use of the images by third parties, who may also use this multimedia for their own purposes.

I release and discharge Elite Sedation, its owners and employees from any and all claims, demands, or causes of action that I may have against them arising out of or in connection with the use of this multimedia.

I hereby acknowledge that I have read and fully understand the terms of this release and that I have had the opportunity to ask any questions that I may have before signing.

By signing this release, I certify that I am at least 18 years of age.

If under 18 years of age, a parent or legal guardian must sign this release.

Patient Name: _____
Patient Signature: _____
Date: _____

(If patient is under 18)
Parent/Guardian Name:_____
Parent/Guardian Signature: _____
Date: _____